Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Medical Nutrition

(Formerly part of Infusion/Enteral/Parenteral)

Billing Instructions

November 2000

About this publication

This publication supersedes the Enteral portion of MAA's Infusion/Enteral/Parenteral Billing Instructions and Numbered Memorandum 00-50 MAA.

Related programs have their own billing instructions. Services and/or equipment related to any of the programs listed below must be billed using their specific billing instructions:

- Home Health Services
- Nutritional Counseling
- Prescription Drug Program

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
November 2000

Where do I get other copies of billing instructions?

Check out MAA's web site
http://maa.dshs.wa.gov **-or-**

Write/Call:
Provider Relations Unit
PO Box 45562
Olympia, WA 98504-5562
1-800-562-6188

Received too many billing instructions?
Too few?
Address incorrect?
Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. (WAC 388-502-0020(2)).

Where do I call for information on becoming a DSHS provider?

Provider Enrollment Unit
(800) 562-6188, **Select Option 1** or call
(360) 725-1033
(360) 725-1026
(360) 725-1032

Where do I send my HCFA-1500 claims?

Hard Copy Claims:
Division of Program Support
PO Box 9247
Olympia WA 98507-9247

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain a limitation extension?

Copy and complete the Limitation Extension Request Form (included in this billing instruction) and fax to:

(360) 586-2262

Who do I contact if I have questions on…

Payments, denials, general questions regarding claims processing, Healthy Options?

Provider Relations Unit (PRU)
1-800-562-6188

Private insurance or third party liability, other than Healthy Options?

Division of Client Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
1-800-562-6136

Access Issues, Broker Transportation, Client Complaints, Healthy Options Enrollment, Disenrollment, Exemptions?

Medical Assistance Customer Service Center (MACSC) (Clients Only)
1-800-562-3022

Eligibility for Children's Medical, Healthy Options and Basic Health Plus?

Medical Eligibility Determination Services (MEDS)
1-800-204-6429

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Definitions

This section defines terms and acronyms used throughout these billing instructions.

Acute - A medical condition of severe intensity with sudden onset.

Authorization – MAA official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

By Report (BR) - When a service, supply, or piece of equipment is new (its use is not yet considered standard), or it is a variation on a standard practice, or it is rarely provided, or it has no maximum allowance established, it may be designated ***By Report***. Any service or item classified as ***By Report*** is evaluated for its medical appropriateness and maximum allowance on a case-by-case basis.

Client - An applicant for, or recipient of, DSHS medical care programs. (WAC 388-500-0005)

Client Support, Division of (DCS) – The division within MAA responsible for:

- Client enrollments, exemptions and disenrollments in managed care plans;
- Coordination of Medicare and private insurance benefits;
- Transportation and interpreter services;
- Operation of a customer service hot-line;
- Administration of a centralized children's eligibility section and Children's Health Insurance Program (CHIP) eligibility policy, marketing and outreach.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. (WAC 388-500-0005)

Core Provider Agreement - A basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in the MAA program.

Deductible - An initial, specified, amount that is the responsibility of the client.

(a) Part A of Medicare - inpatient hospital deductible' means an initial amount of the medical care cost in each benefit period which Medicare does not pay.

(b) Part B of Medicare - physician deductible' means an initial amount of Medicare Part B covered expenses in each calendar year which Medicare does not pay. (WAC 388-500-0005)

Department - The state Department of Social and Health Services [DSHS]. (WAC 388-500-0005)

Durable Medical Equipment (DME) – Equipment that:

(a) Can withstand repeated use;
(b) Is primarily and customarily used to serve a medical purpose;
(c) Generally is not useful to a person in the absence of illness or injury; and
(d) Is appropriate for use in the client's place of residence.

Duration of Therapy - The estimated span of time that therapy will be needed for a medical problem.

Emergency Services - Services provided for care required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Episode - A continuous period of treatment regardless of the number of therapies involved.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Home Health Agency - An agency or organization certified under Medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence.
(WAC 388-551-2010)

Internal Control Number (ICN) - A 17-digit number that appears on your *Remittance and Status Report* by the client's name. Each claim is assigned an ICN when it is received by MAA. The number identifies that claim throughout the claim's history.

Limitation Extension – Prior authorization from MAA to exceed the service limits (quantity, frequency, or duration) set in WAC or in MAA's billing instructions.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
(WAC 388-538-050)

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The state and federal funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Care Provider – Physician, Physician Assistant (PA), Advanced Registered Nurse Practitioner (ARNP), and Certified Dietitian.

Medical Consultant - A physician employed by the department. (WAC 388-500-0005)

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

Medical Nutrition Therapy – The use of medical formulas, either alone or in combination with traditional food, when a client is unable to consume enough traditional food to meet their nutritional requirements. Medical nutritionals can be given orally or via feeding tubes.

Medical Nutritionals – The medical products used when providing Medical Nutrition Therapy.

Medicare - The federal government health insurance program, for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. (WAC 388-500-0005)

Parenteral Nutrition - A type of therapy considered reasonable and necessary for a client with severe pathology of the alimentary tract which consists of the administration of nutrients (i.e., glucose, amino acids, fats, vitamins and minerals) intravenously either by central or by peripheral vein. Parenteral nutrition is appropriate only when oral or enteral feeding is inadequate or contraindicated.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client consisting of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Prior Authorization – Approval required from MAA prior to providing services, for certain services, items, or supplies based on medical necessity.

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Administrative Match Services to Schools and Health Departments;
- Managed Care Contracts;
- Provider Enrollment/Relations; and
- Regulatory Improvement.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Provider Number – A seven-digit identification number issued to service providers who have signed the appropriate contract(s) with MAA.

Purchase Only (P.O.) - A type of purchase used only when either the cost of the item makes purchasing it more cost effective than renting it, or it is a personal item, such as a ventilator mask, appropriate only for a single user.

Remittance And Status Report (RA) - A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Rental - A monthly or daily rental fee paid for equipment.

Revised Code of Washington (RCW) - Washington state laws.

Skilled Nursing Facility (SNF) - An institution or part of an institution which is primarily engaged in providing:

- Skilled nursing care and related services for residents who require medical or nursing care;
- Rehabilitation services for injured, disabled or sick clients;
- Health-related care and services to individuals who, because of their mental or physical conditions, require care which can only be provided through institutional facilities

and which is not primarily for the care and treatment of mental diseases. (See Section 1919(a) of the Federal Social Security Act for specific requirements.)

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. (WAC 388-500-0005)

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005

Total Medical Nutrition – Medical nutritionals used to meet 100% of a client's nutritional requirement.

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

1) The usual and customary charge that you bill the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) Codified rules of the State of Washington.

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About the Program

What is the purpose of MAA's Medical Nutrition Program?

The purpose of MAA's Medical Nutrition Program is to reimburse for medically necessary nutritionals and related supplies, when the client is unable to meet daily nutritional requirements using traditional foods alone, due to injury or illness.

> **Note:** All medical nutrition must be medically necessary and the medical necessity for the product being supplied must be evident in the diagnostic code on the claim. If the diagnostic code on the claim does not support the medical need for medical nutrition, MAA may recoup the payment.

Who is eligible to bill for medical nutrition?

Providers that have been assigned MAA provider numbers for the following provider types:

- Durable Medical Equipment; and/or
- Pharmacy.

See *Important Contacts* section for information on applying for a provider number.

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Client Eligibility

Who is eligible?

Clients presenting Medical Assistance IDentification (MAID) cards with the following identifiers are eligible for medical nutrition and supplies:

MAID Identifier	Medical Program
CNP	Categorically Needy Program
CNP - Children's Health	Categorically Needy Program – Children's Health
CNP - CHIP	Categorically Needy Program – Children's Health Insurance Program
GA-U No Out of State Care	General Assistance – Unemployable
LCP - MNP	Limited Casualty Program-Medically Needy Program
QMB-Medicare Only	Qualified Medicare Beneficiary – Medicare Only **See page I.5 for details of coverage.**

Are clients enrolled in a Healthy Option's managed care plan eligible for medical nutrition?

Yes! Clients who are enrolled in a Healthy Option's managed care plan are eligible for medical nutrition. These clients will have an HMO identifier in the HMO column on their MAID cards. Medical nutritionals and supplies must be requested through the client's Primary Care Provider (PCP). See the 1-800 telephone number listed on the client's MAID card.

☞ **Note:** If you treat a Healthy Options client and you are not the client's Primary Care Provider (PCP), or the client was not referred to you by the PCP, you may not receive payment. You will need to contact the PCP to get a referral. You may also need to get authorization from the plan for the service that you are providing, especially if you are not contracted as a provider with that plan. Call the Managed Care Plan to discuss payment before you provide services.

Newborns of Healthy Options clients are the responsibility of the mother's plan for the first 60 days of life. If the mother changes plans, the baby follows the mother.

Primary Care Case Manager/Management:

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain their services through the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a plan setting. Please refer to the client's MAID card for the PCCM.

Coverage

> **Note: All medical nutrition must be medically necessary and the medical necessity for the product being supplied must be evident in the diagnosis code on the claim. If the diagnosis code does not evidence the medical need for medical nutrition, MAA may recoup the payment.**

MAA's previous policy of medical nutritional being allowed only when 50% of the client's caloric need is no longer applicable. See Modifier section.

- All products and supplies must be medically necessary and meet the guidelines in this billing instruction.
- Unless otherwise approved through the limitation extension process, MAA covers only the products listed in this billing instruction.
- For non-formula products covered by MAA, the product name will include the type of product (e.g., bars).
- Only medical nutritionals with an individually assigned procedure code listed in the fee schedule will be considered for coverage by MAA.
- The client's Department of Health's Supplemental Nutrition Program for Women, Infants, and Children (WIC) allotments must be depleted (when applicable) prior to billing MAA for any medical nutritionals.
- MAA does not pay for:
  - ✓ Medical nutritionals when nutritional needs can be met using traditional foods; and/or
  - ✓ Baby food and other regular grocery products that can be pulverized and used as medical nutritionals.
- A certified dietitian must evaluate all clients 17 years of age and younger within 30 days of initiation of medical nutritionals, and periodically (at the discretion of the certified dietitian) while on medical nutritionals. A copy of this evaluation must be retained in the client's file.

  With dates of service on and after January 1, 2001, the above mentioned certified dietitians must have an MAA-assigned provider number.

Nutritional Counseling

MAA pays for nutritional counseling services provided by a certified dietitian, for clients 20 years of age and younger, when the client is referred by a Healthy Kids/EPSDT provider.

Refer to MAA's Nutritional Counseling Billing Instructions, dated October 2000, for further information (see *Important Contacts* section for information on where to get copies of billing instructions).

Effective for dates of service on and after January 1, 2001, providers billing for medical nutritionals for clients 17 years of age and younger must put the provider number of the certified dietitian in field 17A on the HCFA-1500 claim form.

WIC

(Supplemental Nutrition Program for Women, Infants, and Children)

Before billing MAA for medical nutritionals **(oral and tube fed)** for clients 4 years of age and younger, you must have one of the following:

1. WIC denial and an "F" indicator on the claim indicating that WIC is not being used; or
2. Documentation that the client's WIC allotment has been depleted.

Anytime WIC is not being used for clients 4 years old and younger, you must use an "F" indicator in field 19 on the HCFA-1500 claim form.

Clients in a Nursing Facility

- Medical nutritionals (and related supplies) are not included in the nursing facility per diem when the:

  - ✓ Medical nutritionals are used to meet 100% of the client's nutritional demands;* and
  - ✓ Client's medical circumstance(s) qualify for the use of medical nutritionals.

  * When billing for client's in nursing homes that qualify for reimbursement of medical nutritionals, providers must add the statement *"100 % nutrition - not included in NH"* in field 19 of the HCFA-1500 claim form or in the *Remarks* field on electronic claims.

Clients in a State-Owned Facility

All medical nutrition products/supplies/equipment for MAA clients in state-owned facilities (state school, developmental disabilities (DD) facilities, mental health facilities, Western and Eastern state hospitals) are purchased by the facilities through a contract with manufacturers. Services for these clients are not reimbursed separately by MAA.

Clients who have elected MAA's hospice benefit

MAA pays for medical nutritionals, separate from the hospice per diem, only when the reason for the medical nutritionals is completely unrelated to the terminal diagnosis that qualifies the client for the hospice benefit. You must enter a "K" indicator in field 19 on the HCFA-1500 claim form to identify that the medical nutritionals are **unrelated to the terminal diagnosis.**

Clients who are receiving Medicare Part B Benefits

MAA pays for medical nutritionals for clients on Medicare Part B only when the clients are not tube-fed and when the client meets the criteria in these billing instructions. When billing for these clients, it is not necessary to bill with a Medicare denial. However, you must put the statement *"Not tube fed - Medicare does not cover"* in field 19 of the HCFA-1500 claim form or in the *Remarks* field on electronic claims.

Medical Nutritionals Used In Combination with Parenteral Nutrition

Can I get paid for both Medical Nutritionals and Parenteral Nutrition?

MAA pays for up to 3 months of medical nutritionals/supplies and parenteral nutrition/supplies while a client is being transitioned from parenteral to medical nutritionals.

If the transition period exceeds 3 months, you must enter an "L" indicator in field 19 on the HCFA-1500 claim form to indicate that while the expected transition time has been exceeded, the client is still transitioning to medical nutritionals.

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Modifiers/Criteria

Effective with dates of service on and after November 1, 2000, providers must use the new procedure codes along with the appropriate modifier for all medical nutritionals. Claims for medical nutritionals that are missing the modifier will be denied.

What does the modifier signify?

The modifier signifies that the client meets all of the criteria associated with the modifier. Providers must document how the client meets the criteria and keep this information in the client's file and accessible to MAA upon request.

Keep in mind…

- For infants (clients 12 months of age and younger), MAA covers only the portion of oral non-specialty infant products that are in excess of the normal intake requirement for this age group.

- Tube feedings may be provided in the home only when the prescribing provider has determined that it can be done safely and effectively.

Oral Non-Specialty Products – Pediatric	
Modifier	**Criteria**
2B	• Client is 4 years of age or younger; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Due to illness or injury, the metabolic demand exceeds the normal nutritional requirement for age group; **and** • WIC eligibility is denied.*
2C	• Client is 4 years of age or younger; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Client has a properly diagnosed feeding problem that prohibits the client from meeting his/her nutritional requirements with traditional foods alone; **and** • WIC eligibility is denied.*
2D	• Client is 4 years of age or younger; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Due to illness or injury, the metabolic demand exceeds the normal nutritional requirement for age group; **and** • Client has a proven intolerance to WIC-covered formula.*
2E	• Client is 4 years of age or younger; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Client has a properly diagnosed feeding problem that prohibits the client from meeting his/her nutritional requirements with traditional foods alone; **and** • Client has a proven intolerance to WIC-covered formula.*
2F	• Client is 4 years of age or younger; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Due to illness or injury, the metabolic demand exceeds the normal nutritional requirement for age group and cannot be met with traditional foods alone; **and** • Formula being billed is in addition to WIC allotment.

***Note:** **When WIC is not being used for clients 4 years old and under, you must use an "F" indicator in field 19 on the HCFA-1500 claim form.**

Oral Non-Specialty Products – Pediatric (cont.)	
Modifier	**Criteria**
2G	• Client is 4 years of age or younger; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Client has a properly diagnosed feeding problem that prohibits the client from meeting his/her nutritional requirements with traditional foods alone; **and** • Formula being billed is in addition to WIC allotment.
2H	• Client is between the ages of 4 and 18 years old; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Due to illness or injury, the metabolic demand exceeds the normal nutritional requirement for age group and cannot be met with traditional foods alone.
2T	• Client is between the ages of 4 and 18 years old; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Client has a properly diagnosed feeding problem that prohibits the client from meeting his/her nutritional requirements with traditional foods alone.

***Note:** **When WIC is not being used for clients 4 years old and under, you must use an "F" indicator in field 19 on the HCFA-1500 claim form.**

Oral Specialty Products – Pediatric	
Modifier	**Criteria**
3B	• Client is 4 years of age or younger; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Due to illness or injury, the client's nutritional requirements cannot be met with non-speciality formula and/or traditional food alone; **and** • WIC eligibility is denied.*
3C	• Client is 4 years of age or younger; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Client has a properly diagnosed feeding problem that prohibits the client from meeting his/her nutritional requirements with traditional foods alone; **and** • Client's nutritional requirements cannot be met with non-specialty formula; **and** • WIC eligibility is denied.*
3D	• Client is 4 years of age or younger; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Due to illness or injury, the client's nutritional requirements cannot be met with non-specialty formula and/or traditional foods alone • WIC does not cover the product.*
3E	• Client is 4 years of age or younger; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Client has a properly diagnosed feeding problem that prohibits the client from meeting his/her nutritional requirements with traditional foods alone; **and** • Client's nutritional requirements cannot be met with non-specialty formula; **and** • WIC does not cover the product.*
3F	• Client is 4 years of age or younger; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Due to illness or injury, the client's nutritional requirements cannot be met with non-specialty formula and/or traditional foods alone; **and** • Client has proven intolerance to WIC-covered specialty formulas.*

***Note: When WIC is not being used for clients 4 years old and under, you must use an "F" indicator in field 19 on the HCFA-1500 claim form.**

Oral Specialty Products – Pediatric (cont.)	
Modifier	**Criteria**
3G	• Client is 4 years of age or younger; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Client has a properly diagnosed feeding problem that prohibits the client from meeting his/her nutritional requirements with traditional foods alone; **and** • Client's nutritional requirements cannot be met with non-specialty formula**;** and • Client has proven intolerance to WIC-covered specialty formulas.*
3H	• Client is 4 years of age or younger; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Due to illness or injury, the client's nutritional requirements cannot be met with non-specialty formula and/or traditional foods alone; **and** • Formula being billed is in addition to WIC allotment.
3J	• Client is 4 years of age or younger; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Client has a properly diagnosed feeding problem that prohibits the client from meeting his/her nutritional requirements with traditional foods alone; **and** • Client's nutritional requirements cannot be met with non-specialty formula; **and** • Formula being billed is in addition to WIC allotment.
3K	• Client is between the ages of 4 and 18 years old; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Due to illness or injury, the client's nutritional requirements cannot be met with non-specialty formula and/or traditional foods alone.
3M	• Client is between the ages of 4 and 18 years old; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Client has a properly diagnosed feeding problem that prohibits the client from meeting his/her nutritional requirements with traditional foods alone; **and** • Client's nutritional requirements cannot be met with non-specialty formula.

***Note: When WIC is not being used for clients 4 years old and under, you must use an "F" indicator in field 19 on the HCFA-1500 claim form.**

Tube Fed Non-Specialty Products – Pediatric	
Modifier	**Criteria**
3N	• Client is 4 years of age or younger; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Formula being billed is in addition to WIC allotment*; **and** • It is medically necessary for the client to be tube fed.
3T	• Client is 4 years of age or younger; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Client has a WIC eligibility denial*; **and** • It is medically necessary for the client to be tube fed.
3V	• Client is 4 years of age or younger; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • Client has proven intolerance to WIC-covered formulas or client is over 1 year old and WIC formula is not medically appropriate; **and** • It is medically necessary for the client to be tube fed.
3W	• Client is between the ages of 4 and 18 years old; and • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • It is medically necessary for the client to be tube fed.

***Note:** **When WIC is not being used for clients 4 years old and under, you must use an "F" indicator in field 19 on the HCFA-1500 claim form.**

Tube Fed Specialty Products – Pediatric	
Modifier	**Criteria**
3Q	• Client is 4 years of age or younger; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • It is medically necessary for the client to be tube fed; **or** • Due to illness or injury, the client's nutritional requirements cannot be met with WIC-covered or non-specialty formula; **and** • Client has WIC eligibility denial***.**
3R	• Client is between the ages of 4 and 18 years old; **and** • Client is evaluated by a certified dietitian within 30 days of initiation of medical nutritionals, and periodically thereafter; **and** • It is medically necessary for the client to be tube fed.

Oral Non-Specialty Products – Adults	
Modifier	**Criteria**
4A	• Due to illness or injury, the metabolic demand exceeds the normal requirement and cannot be met with traditional foods alone.

Oral Specialty Products – Adults	
Modifier	**Criteria**
4B	• Due to illness or injury, the metabolic demand exceeds the normal requirement and cannot be met with non-specialty formula and/or traditional foods alone.

Tube Fed Non-Specialty Products – Adults	
Modifier	**Criteria**
4C	• It is medically necessary for the client to be tube fed; **and** • Medical nutritional payment is not part of an established per diem rate.

***Note: When WIC is not being used for clients 4 years old and under, you must use an "F" indicator in field 19 on the HCFA-1500 claim form.**

Tube Fed Specialty Products – Adults	
Modifier	**Criteria**
4D	• Due to illness or injury, the client's nutritional requirements cannot be met with non-specialty formula; **and** • It is medically necessary for the client to be tube fed; **and** • Medical nutritional payment is not part of an established per diem rate.

Protein – Pediatric	
Modifier	**Criteria**
9A	• A Certified Dietitian's evaluation concludes that, due to illness or injury, the client's protein need exceeds normal protein requirement, and this need cannot be met with formula and/or traditional foods alone.

Protein – Adults	
Modifier	**Criteria**
9B	• A medical care provider's evaluation concludes that, due to illness or injury, the client's protein need exceeds normal protein requirements, and this need cannot be met with traditional foods alone.

Fats – Pediatric	
Modifier	**Criteria**
9C	• A Certified Dietitian's evaluation concludes that, due to illness or injury, the client's energy need (from fat) exceeds normal energy requirement (from fat), and this need cannot be met with formula and/or traditional foods alone

Fats – Adults	
Modifier	**Criteria**
9D	• A medical care provider's evaluation concludes that, due to illness or injury, the client's energy need (from fat) exceeds normal energy requirements (from fat), and this need cannot be met with traditional foods alone.

Carbohydrates – Pediatric	
Modifier	**Criteria**
9E	• A Certified Dietitian's evaluation concludes that, due to illness or injury, the client's energy need (from carbohydrates) exceeds normal energy requirement (from carbohydrates), and this need cannot be met with formula and/or traditional foods alone.

Carbohydrates – Adults	
Modifier	**Criteria**
9F	• A medical care provider's evaluation concludes that, due to illness or injury, the client's energy need (from carbohydrates) exceeds normal energy requirements (from carbohydrates), and this need cannot be met with traditional foods alone.

Thickeners – Pediatric/Adults	
Modifier	**Criteria**
9G	• Speech therapist evaluation with a diagnosis of dysphagia.

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Product List

Effective with dates of service on and after July 1, 2002, providers must use the new procedure codes along with the appropriate modifier for all medical nutritional claims. Claims that are missing the modifier will be denied.

Product Name	Procedure Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Round monthly total # of calories to the nearest 100 calories.			
Advera*	0000B	100 cal	$1.90
Additions **(Eff. 10/1/02)** Website Update Only	0412B	100 cal	$.50
Alimentum*	0001B	100 cal	$3.55
AlitraQ	0002B	100 cal	$3.55
Amino-Aid	0003B	100 cal	$0.68
Beneprotein (formerly known as Resource Instant Protein Powder) **(Eff. 10/16/02)** Website Update Only	0405B	1pwd oz	$1.70
Boost	0004B	100 cal	$1.04
Boost Breeze **(Eff. 7/1/02)** Website Update Only	0400B	100 cal	$1.04
Boost HP	0005B	100 cal	$1.04
Boost Plus	0006B	100 cal	$0.68
Boost w/Fiber	0007B	100 cal	$1.04
Calcilco XD Pwd **(Eff. 9/1/01)** Website Update Only	0388B	100 cal	$1.04
Carnation Alsoy	0008B	100 cal	$1.04
Carnation Follow-up	0009B	100 cal	$1.04
Carnation Good Start	0010B	100 cal	$1.04
Casec	0011B	1 pwd oz	$1.69
Choice DM	0012B	100 cal	$1.04
Choice DM Bar	0013B	100 cal	$0.72
Compleat Modified	0014B	100 cal	$1.04
Compleat Pediatric	0015B	100 cal	$1.04

These products are considered supplies and cannot be billed on-line through the POS system.
*** Specialty Product**

Product Name	Procedure Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Round monthly total # of calories to the nearest 100 calories.			
Comply	0016B	100 cal	$0.68
Criticare HN	0017B	100 cal	$3.55
Crucial	0019B	100 cal	$3.55
Cyclinex 1*	0021B	100 cal	$1.04
Cyclinex 2*	0023B	100 cal	$3.55
Deliver 2.0	0025B	100 cal	$0.68
Diabetisource	0027B	100 cal	$1.04
Diabetisource AC **(Eff. 10/1/02)** Website Update Only	0411B	100 cal	$1.22
Duocal **(Eff. 1/1/03)** Website Update Only	0414B	100 cal	$.092
Elecare	0028B	100 cal	$1.90
Enfacare	0029B	100 cal	$1.04
Enfamil	0365B	100 cal	$1.04
Enfamil 22	0030B	100 cal	$1.04
Enfamil AR	0031B	100 cal	$1.04
Enfamil LactoFree	0032B	100 cal	$1.04
Enfamil Next Step	0033B	100 cal	$1.04
Enlive	0034B	100 cal	$1.04
Ensure Bar	0035B	100 cal	$0.72
Ensure High Protein	0036B	100 cal	$1.04
Ensure Plus	0037B	100 cal	$0.68
Ensure Plus HN	0038B	100 cal	$0.68
Ensure with or without Fiber	0039B	100 cal	$1.04
FAA (Free Amino Acid Diet)* **(Eff. 6/1/02)** Website Update Only	0397B	100 cal	$3.55
FiberSource	0040B	100 cal	$1.04
FiberSource HN	0041B	100 cal	$1.04
GA 1 and 2*	0042B	100 cal	$3.55

These products are considered supplies and cannot be billed on-line through the POS system.
*** Specialty Product**

Product Name	Procedure Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Round monthly total # of calories to the nearest 100 calories.			
Generic/Store Brand Formula (Eff. 7/1/02) Website Update Only ***Note:*** *Providers may bill for Generic or Store Brand products only when the content of the product is the same as Ensure, Boost, or NuBasic.*	0399B	100 cal	$1.00
Glucerna	0043B	100 cal	$1.04
Glucerna Bar	0044B	100 cal	$0.72
Glucerna OS	0045B	100 cal	$1.04
Glutarex 1*	0046B	100 cal	$1.90
Glutarex 2*	0047B	100 cal	$4.98
Glutasorb	0385B	100 cal	$3.55
Glytrol	0048B	100 cal	$1.04
HCY 1 and 2*	0049B	100 cal	$4.98
Hepatic-Aid	0050B	100 cal	$4.98
Hominex 1*	0051B	100 cal	$3.55
Hominex 2*	0052B	100 cal	$4.98
Immun-Aid	0053B	100 cal	$3.55
Immunocal **(Eff. 9/1/01)** Website Update Only	0389B	1 pwd oz	$1.69
Impact 1.5	0054B	100 cal	$0.68
Impact with or without fiber	0055B	100 cal	$0.68
Impact Glutamine **(Eff. 1/1/03)** Website Update Only	0417B	100 cal	$3.14
Impact Recover **(Eff. 1/1/03)** Website Update Only	0415B	100 cal	$0.93
Isocal	0056B	100 cal	$1.04
Isocal HN	0057B	100 cal	$1.04
Isocal HN Plus **(Eff. 9/1/01)** Website Update Only	0390B	100 cal	$1.04
Isomil	0059B	100 cal	$1.04
Isomil DF	0061B	100 cal	$1.04

These products are considered supplies and cannot be billed on-line through the POS system.
*** Specialty Product**

Product Name	Procedure Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Round monthly total # of calories to the nearest 100 calories.			
Isosource	0063B	100 cal	$1.04
Isosource 1.5	0064B	100 cal	$0.68
Isosource HN	0065B	100 cal	$1.04
IsoSource VHN	0066B	100 cal	$1.04
Isotein HN	0067B	100 cal	$3.55
Jevity	0068B	100 cal	$1.04
Jevity Plus	0069B	100 cal	$1.04
KetoCal* (**Eff. 9/1/02**) Website Update Only	0410B	100 cal	$1.22
Ketonex 1*	0071B	100 cal	$1.90
Ketonex 2*	0073B	100 cal	$4.98
Kindercal	0075B	100 cal	$1.04
Kindercal TF w/Fiber **(Eff. 9/1/01)** Website Update Only	0391B	100 cal	$1.04
Lipisorb Liquid	0077B	100 cal	$1.04
L-Emental*	0380B	100 cal	$3.55
L-Emental Hepatic*	0381B	100 cal	$3.55
Lofenelac*	0079B	100 cal	$1.04
LYS 1 and 2*	0081B	100 cal	$1.90
Magnacal Renal	0083B	100 cal	$0.68
MCT Oil	0085B	1 fl oz	$1.28
Microlipids	0087B	1 fl oz	$1.28
Modulen IBD **(Eff. 9/1/01)** Website Update Only	0395B	100 cal	$1.58
MSUD*	0089B	100 cal	$1.90
MSUD 2*	0091B	100 cal	$3.55
Neocate*	0093B	100 cal	$3.55
Neocate One Plus*	0095B	100 cal	$3.55
NeoSure	0097B	100 cal	$1.04
Nepro	0100B	100 cal	$0.68
Novasource 2.0 (**Eff. 10/1/02**) Website Update Only	0406B	100 cal	$.62

These products are considered supplies and cannot be billed on-line through the POS system.
*** Specialty Product**

Product Name	Procedure Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Round monthly total # of calories to the nearest 100 calories.			
Novasource Renal	0101B	100 cal	$0.68
Novasource Pulmonary*	0102B	100 cal	$0.68
NuBasics 2.0	0103B	100 cal	$0.68
NuBasics Bar	0104B	100 cal	$0.72
NuBasics Fruit Beverage	0105B	100 cal	$1.04
NuBasics Plus	0106B	100 cal	$0.68
NuBasics VHP	0107B	100 cal	$1.04
NuBasics with or without fiber	0108B	100 cal	$1.04
Nutramigen*	0109B	100 cal	$3.55
Nutren 1.0 with or without fiber	0110B	100 cal	$1.04
Nutren 1.5	0111B	100 cal	$0.68
Nutren 2.0	0113B	100 cal	$0.68
Nutren JR with or without fiber	0114B	100 cal	$1.04
Nutrihep*	0115B	100 cal	$3.55
Nutrirenal	0370B	100 cal	$0.68
Nutrivent*	0116B	100 cal	$0.68
Optimental* **(Eff. 9/1/01)** Website Update Only	0392B	100 cal	$3.55
OS 1 and 2*	0117B	100 cal	$1.90
Osmolite	0118B	100 cal	$1.04
Osmolite HN	0119B	100 cal	$1.04
Osmolite HN Plus	0120B	100 cal	$1.04
Pediasure with or without fiber	0121B	100 cal	$1.04
Peptamen*	0122B	100 cal	$3.55
Peptamen 1.5*	0123B	100 cal	$3.55
~~Peptamen FOS/Inulin*~~ Name changed. See Peptamen with Prebio 1. **(Eff. 12/02)** Website Update Only	~~0396B~~	~~100 cal~~	~~$3.55~~
Peptamen with Prebio 1 (formerly known as Peptamen FOS/Inulin)* **(Eff. 12/02)** Website Update Only	0396B	100 cal	$3.55
Peptamen Jr.*	0124B	100 cal	$3.55

These products are considered supplies and cannot be billed on-line through the POS system.
*** Specialty Product**

Product Name	Procedure Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Round monthly total # of calories to the nearest 100 calories.			
Peptamen VHP*	0125B	100 cal	$3.55
Peptinex DT* **(Eff. 9/1/02)** Website Update Only	0409B	100 cal	$3.25
Perative*	0126B	100 cal	$1.90
PFD2*	0127B	100 cal	$0.68
Phenex 1*	0128B	100 cal	$3.55
Phenex 2*	0129B	100 cal	$3.55
PhenylAde*	0130B	100 cal	$3.55
PhenylAde MTE*	0131B	100 cal	$4.98
Phenyl-Free*	0132B	100 cal	$1.90
Phenyl-Free 2*	0133B	100 cal	$3.55
Phenyl-Free HP2*	0134B	100 cal	$3.55
Polycose Liquid	0135B	1 fl oz	$0.61
Polycose Powder	0136B	3 Tbs	$0.61
Portagen	0137B	100 cal	$1.04
Pregestimil	0138B	100 cal	$3.55
Probalance	0139B	100 cal	$1.04
Pro-Cel **(Eff. 7/1/02)** Website Update Only	0401B	1 pwd oz	$1.38
Product 3200AB*	0140B	100 cal	$1.04
Product 3232*	0141B	100 cal	$0.68
Product 80056*	0142B	100 cal	$0.68
Promod	0143B	1 pwd oz	$1.69
Promote with or without fiber	0145B	100 cal	$1.04
Pro-Peptide*	0382B	100 cal	$3.55
Pro-Peptide VHN	0383B	100 cal	$3.55
Pro-Peptide for Kids	0384B	100 cal	$3.55
ProPhree	0147B	100 cal	$0.68
Propimex 1*	0149B	100 cal	$1.90
Propimex 2*	0159B	100 cal	$4.98
ProSobee	0160B	100 cal	$1.04
ProSure	0413B	100 cal	$.59

These products are considered supplies and cannot be billed on-line through the POS system.
*** Specialty Product**

Product Name	Procedure Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Round monthly total # of calories to the nearest 100 calories.			
(**Eff. 10/1/02**) Website Update Only			
Protein Eight Bar **(Eff. 4/1/02)** Website Update Only	0387B	100 cal	$0.71
ProViMin*	0164B	100 cal	$3.55
Pulmocare	0167B	100 cal	$0.68
RCF*	0168B	100 cal	$1.04
Re/Neph **(Eff. 9/1/01)** Website Update Only	0393B	100 cal	$0.68
Reabilan*	0169B	100 cal	$3.55
Reabilan HN*	0170B	100 cal	$3.55
Regain Bar	0177B	100 cal	$0.72
Renal Cal*	0178B	100 cal	$3.55
Replete with or without fiber	0179B	100 cal	$1.04
Resource	0180B	100 cal	$1.04
Resource Arginaid* **(Eff. 10/1/02)** Website Update Only	0403B	100 cal	$5.96
Resource Bar	0181B	100 cal	$0.72
Resource Benecalorie **(Eff. 1/1/03)** Website Update Only	0419B	100 cal	$0.77
Resource Diabetic	0182B	100 cal	$1.04
Resource Diabetishield **(Eff. 1/1/03)** Website Update Only	0416B	100 cal	$1.09
Resource Fruit Beverage	0183B	100 cal	$1.04
Resource GlutaSolve (**Eff. 10/1/02**) Website Update Only	0407B	100 cal	$2.06
~~Resource Instant Protein Powder~~ Name changed. See Beneprotein (**Eff. 10/16/02**) Website Update Only	~~0405B~~	~~1pwd oz~~	~~$1.70~~
Resource Just for Kids	0184B	100 cal	$1.04
Resource Plus	0188B	100 cal	$0.68
Resource Thicken Up	0404B	1TBSP	$.09

These products are considered supplies and cannot be billed on-line through the POS system.
*** Specialty Product**

Product Name	Procedure Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Round monthly total # of calories to the nearest 100 calories.			
(**Eff. 10/1/02**) Website Update Only			
Respalor	0189B	100 cal	$0.68
Sando Source Peptide*	0190B	100 cal	$3.55
Similac	0194B	100 cal	$1.04
Similac PM 60/40*	0195B	100 cal	$1.04
~~Steel Bar~~ **(Discontinued April 2002)**	~~0196B~~	~~100 cal~~	~~$.072~~
Subdue*	0197B	100 cal	$3.55
Suplena	0198B	100 cal	$0.68
Thick & Easy	0199B	1TBS	$0.08
Thick-It	0200B	1TBS	$0.08
Tolerex*	0203B	100 cal	$3.55
TraumaCal	0204B	100 cal	$0.68
TwoCal HN	0386B	100 cal	$0.68
Tyrex 2*	0205B	100 cal	$4.98
Tyros 2*	0209B	100 cal	$3.55
UCD 1 and 2*	0210B	100 cal	$3.55
Ultracal	0371B	100 cal	$1.04
Ultracal HN Plus **(Eff. 9/1/01)** Website Update Only	0394B	100 cal	$1.04
Upcal D **(Eff. 7/1/02)** Website Update Only	0402B	1 pwd oz	$1.38
Valex 1*	0217B	100 cal	$1.90
Valex 2*	0218B	100 cal	$3.55
VHC 2.25 **(Eff. 1/1/03)** Website Update Only	0418B	100 cal	$0.36
Vital HN*	0219B	100 cal	$3.55
Vivonex Pediatric*	0376B	100 cal	$3.55
Vivonex Plus*	0377B	100 cal	$3.55
Vivonex TEN*	0220B	100 cal	$3.55

These products are considered supplies and cannot be billed on-line through the POS system.
*** Specialty Product**

Fiber/Hydration Products

Fiber and hydration products are covered on a limited basis through MAA's Prescription Drug Program.

How are products added to the medical nutritional product list?

Suppliers who want to have additional products on this list must submit the following to MAA:

- Product profile;
- Product profile of any similar products already covered by MAA;
- Category recommendation;
- Average wholesale price (AWP); and
- Certification that Medicare has approved product (when applicable).

Send your requests for product consideration to:
Medical Assistance Administration
ATTN: Medical Nutrition
PO Box 45506
Olympia, WA 98504-5506

These products are considered supplies and cannot be billed on-line through the POS system.
*** Specialty Product**

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Authorization

Is prior authorization required for medical nutrition?

Prior authorization **is not required** for medical nutritionals and supplies.

However, prior to payment, MAA will review all claims where the medical nutrition miscellaneous code (4570B) is billed. See page H.7 for further information.

Medical prescriptions and records must document the daily caloric requirement and medical necessity of enteral feeding.

Medical nutrition therapy decisions must be made on the:

a) Estimation of the total nutritional requirements;
b) Estimation of the number of supplemental calories;
c) The client's weight or description of body build;
d) The client's height; and
e) Determination of why an individual's nutritional requirements cannot be part of the daily diet.

This information must be documented in the client's record and made available to MAA upon request.

When should I request a limitation extension for medical nutrition?

Under the Medical Nutrition Program, a limitation extension must be requested when:

- The client does not meet MAA's criteria listed for medical nutritionals and the provider can verify that it is medically necessary to provide medical nutritionals for this client; **and/or**
- It is medically necessary to provide more units of supplies than allowed in MAA's billing instructions.

How do I request a limitation extension?

For medical nutritionals, copy and complete the enclosed Medical Nutrition Limitation Extension Request form.

For additional units of supplies, send or fax medical justification to MAA.

Where do I send my limitation extension request?

Send or fax your request/medical justification to:

Division of Health Services Quality Support
Quality Fee for Service Section- Limitation Extension
PO Box 45506
Olympia, WA 98504-5506
Fax: (360) 586-2262

Note: All limitation extensions are subject to the client's eligibility. Not all eligibility groups receive all services. See Section C - *Client Eligibility*.

Limitation Extension Request

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Fee Schedule

Equipment Rental/Purchase Policy

- The following are considered included in MAA's reimbursement for equipment rentals or purchases:

  - ✓ Instructions to the client and/or caregiver on the safe and proper use of equipment provided;
  - ✓ Full service warranty;
  - ✓ Delivery and pick-up; and
  - ✓ Fitting and adjustments.

- If death, ineligibility, or other change in circumstances occur during the rental period, MAA will terminate reimbursement at the end of that rental period.

- Providers may not bill for a rental and a purchase of any item simultaneously.

- MAA will not reimburse providers for equipment that was supplied to them **at no cost** through suppliers/manufacturers.

- All rent-to-purchase equipment must be new at the beginning of the rental period.

- MAA reimburses for medical nutrition related supplies for client's residing in nursing facilities **only:**

  - ✓ When they are used to administer 100% of the client's nutritional requirements; and
  - ✓ When the client's medical circumstances meet MAA's guidelines for medical nutrition.

- MAA reimburses for medical nutrition related supplies for client's receiving Medicare Part B **only:**

  - ✓ When they are used to administer medical nutritionals to non tube-fed clients; and
  - ✓ When the client's medical circumstances meet MAA's guidelines for medical nutrition.

Fee Schedule ☞

Miscellaneous Procedure Code

In order to be reimbursed for miscellaneous medical nutrition state-unique code (4570B), the attached form must be reviewed by MAA prior to submitting your claim to MAA. Fax the form to MAA for review**.**

Do not submit claims using state-unique code 4570B until you have received a confirmation number from MAA indicating that your bill has been reviewed.

Include the following supporting documentation with your fax:

- ✓ Agency name and provider number;
- ✓ Client PIC;
- ✓ Date of service;
- ✓ Name of piece of equipment;
- ✓ Invoice;
- ✓ Prescription;
- ✓ Explanation of client-specific, medical necessity; and
- ✓ Name of primary piece of equipment and whether the equipment is rented or owned.

Make copies of the attached form and mail/fax to:

Medical Assistance Administration
Medical Nutrition Program
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-2262

Justification for use of Misc. Code Form

General Billing

Do not bill medical nutritionals under MAA's Prescription Drug Program through Point of Sale

What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timelines standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

Note:	If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date of recoupment by the plan.

[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service.

- MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  Note: MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

How do I bill for services provided to PCCM clients?

When billing for services provided to Primary Care Case Manager (PCCM) clients:

- Enter the referring physician or PCCM name in field 17 on the HCFA-1500 claim form; and

- Enter the seven-digit identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

How do I bill for clients eligible for Medicare and Medical Assistance?

If a client is eligible for both Medicare and Medical Assistance, **you must <u>first</u> submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claims.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims (see page I.1).

Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

- If Medicare has made payment, and there is a balance due from MAA, you must submit a HCFA-1500 claim form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do no submit paid lines with denied lines. This could cause a delay in payment.

- If Medicare denies services, but MAA covers them, you must bill on a HCFA-1500 claim form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment.

- If Medicare denies a service that requires prior authorization by MAA, MAA will waive the prior authorization requirement but will still require authorization. Authorization or denial of your request will be based upon medical necessity.

NOTE:

- ✓ **Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.**
- ✓ **A Medicare Remittance Notice or EOMB must be attached to each claim.**

Payment Methodology – Part B

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, we use Medicare's allowed amount.)
- Medicare's payment is deducted from the amount selected above.
- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.
- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when:

1) The provider accepts assignment; and

2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

QMB (Qualified Medicare Beneficiaries) Program Limitations:

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their MAID card in addition to QMB)

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

- If only Medicaid **and not Medicare** cover the service and the service is covered under the CNP or MNP program, MAA will reimburse for the service.

QMB-Medicare Only

The reimbursement criteria for this program are as follows:

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

For QMB-Medicare Only:
If **Medicare** does not cover the service,
MAA will not reimburse the service.

What must I keep in a client's file? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome;
  - ✓ Specific claims and payments received for services; and

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

Required documentation specific to this program:

The following must be documented in the client's medical record:

- Justification of the medical need for medical nutritionals;
- Justification for the method of administration when client is tube fed; and
- Copy of the medical care provider's prescription.

Additional information necessary for clients 20 years of age and younger:

- WIC denial for clients 5 years of age and younger; and
- A copy of the certified dietitian's initial evaluation, no more than 30 days after the initiation of medical nutritionals, and any follow-up evaluations done while the client is receiving medical nutritionals.

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- All information must be centered within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

Field Description

1a. **Insured's ID No.**: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each MAA client - exactly as shown on the Medical Assistance IDentification (MAID) card consisting of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare,

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payer of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: For clients 17 years of age and younger, enter the certified dietitian's name.

17a. **ID Number of Referring Physician**: For clients 17 years of age and younger, enter the MAA 7-digit certified dietitian provider number. **AS OF 01/01/01, THIS WILL BE A REQUIRED FIELD.**

19. **Reserved for Local Use**: When applicable, enter one of the following indicators:

"**B" -** *Baby on Parent's PIC. (*Please specify twin A or B, triplet A, B, or C here)

"F" – Clients 4 years of age and younger when WIC is not being used.

"K" – Clients who have elected the hospice benefit, when billed charges are unrelated to the terminal diagnosis.

"L" – When the transition time from parenteral nutrition to medical nutritionals is greater than 3 months.

☞ **(see next column for more "indicators…)**

"**100 % nutrition - not included in NH**" **-** When billing for medical nutritionals for nursing home clients (see page D.3).

"**Not tube fed - Medicare does not cover.**"- When client has Medicare Part B (see page D.3).

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the *Remittance and Status Report*.)

23. **Prior Authorization Number**: When applicable. If the service or equipment you are billing requires authorization, enter the 9-digit number assigned to you. Only one authorization number is allowed per claim.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., November 8, 2000 = 110800). ***Bill must not exceed a 1-month supply.***

24B. **Place of Service**: Required. Enter the following code:

Code	To Be Used For
2	Outpatient hospital
4	Client's residence
7	Nursing facility (formerly ICF)
8	Nursing facility (formerly SNF)

24C. **Type of Service**: Required. Enter a **9** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate Current Procedural Terminology (CPT) or HCFA Common Procedure Coding System (HCPCS) procedure code for the services being billed.

Modifier: Must use the appropriate modifier when billing for medical nutritionals and supplies.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code that evidences the need for the use of medical nutritionals. A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units (not to exceed a 1-month supply) for each line. These figures must be whole units.

25. **Federal Tax ID Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your *Remittance and Status Report* under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code And Phone #**: Required. Put the *Name, Address,* and *Telephone Number* on all claim forms.

GRP#: **Required.** Enter the 7-digit provider number assigned by MAA.

Sample HCFA-1500 Claim Form

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Common Questions Regarding Medicare Part B/ Medicaid Crossover Claims

Q: Why do I have to mark "XO," in box 19 on crossover claim?

A: The "XO" allows our mailroom staff to identify crossover claims easily, ensuring accurate processing for payment.

Q: Where do I indicate the coinsurance and deductible?

A: You must enter the total combined coinsurance and deductible in field 24D on each detail line on the claim form.

Q: What fields do I use for HCFA-1500 Medicare information?

A: <u>In Field:Please Enter:</u>

19	an "XO"
24D	total combined coinsurance and deductible
24K	Medicare's allowed charges
29	Medicare's total deductible
30	Medicare's total payment
32	Medicare's EOMB process date, and the third-party liability amount

Q: When I bill Medicare denied lines to MAA, why is the claim denied?

A: Your bill is not a crossover when Medicare denies your claim or if you are billing for Medicare-denied lines. The Medicare EOMB must be attached to the claim. Do not indicate "XO."

Q: How do my claims reach MAA?

A: After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to MAA for any supplemental Medicaid payment. When the words, *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer.

If **Medicare has paid** and the Medicare crossover claim does not appear on the MAA Remittance and Status Report within 30 days of the Medicare statement date, you should bill MAA on the HCFA-1500 claim form.

If **Medicare denies** a service, bill MAA using the HCFA-1500 claim form. Be sure the Medicare denial letter or EOMB is attached to your claim to avoid delayed or denied payment due to late submission.

REMEMBER! You must submit your claim to MAA within six months of the Medicare statement date if Medicare has paid or 365 days from date of service if Medicare has denied.

How to Complete the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

> The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be billed electronically.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

Field Description

1a. **Insured's I.D. No.:** Required. Enter the MAA Patient Identification Code (PIC) - an alphanumeric code assigned to each MAA client. This information is obtained from the client's current Medical Assistance IDentification (MAID) card consisting of:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- ✓ Mary C. Johnson's PIC looks like this: MC010633JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

2. **Patient's Name:** Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate:** Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial):** When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address:** Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*).

9. **Other Insured's Name:** Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To:** Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number:** Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. **Insured's Date of Birth:** Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name:** Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name:** Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*.

17. **Name of Referring Physician or Other Source**: For clients 5 years of age and younger, enter the certified dietitian's name.

17a. **ID Number of Referring Physician**: For clients 20 years of age and younger, enter the MAA 7-digit certified dietitian provider number. **AS OF 01/01/01, THIS WILL BE A REQUIRED FIELD.**

19. **Reserved For Local Use: Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **Medicaid Resubmission:** When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.**

24A. **Date(s) of Service:** Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., November 4, 2000 = 110400). **Do not use slashes, dashes, or hyphens to separate month, day or year (MMDDYY).**

24B. **Place of Service:** Required. Enter the following code:

Code	To Be Used For
2	Outpatient hospital
4	Client's residence
7	Nursing facility (formerly ICF)
8	Nursing facility (formerly SNF)

24C. **Type of Service:** Required. Enter a 9.

24D. **Procedures, Services or Supplies CPT/HCPCS: Required. Coinsurance and Deductible:** Enter the total combined and deductible for each service in the space to the right of the modifier on each detail line.

24E. **Diagnosis Code:** Required. Enter the ICD-9-CM diagnosis code that evidences the need for the use of medical nutritionals. A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume.

24F. **$ Charges:** Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24G. **Days or Units:** Required. Enter appropriate number of units.

24K. **Reserved for Local Use:** Required. Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).

26. **Your Patient's Account No.:** Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. **Accept Assignment:** ***Required.*** Check **yes**.

28. **Total Charge:** Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid:** Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. **Balance Due:** Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. **Name and Address of Facility Where Services Are Rendered:** Required. Enter Medicare Statement Date *and* any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #:** Required. Put the *Name*, *Address*, and *Telephone Number* on all claim forms.

GRP#: **Required.** Enter the 7-digit provider number assigned by MAA.

Sample Medicare XOver

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